Patient Name _____ Date _____

HEPATITIS C WORKSHEET

Does this patient have a persistently normal ALT value?	Yes	No
Is this patient currently using alcohol or street drugs?	Yes	No
Is this patient high risk due to clinical depression?	Yes	No
Is this patient anemic? (Hb< 12 b/dl- women; <12 g/dl- men)	Yes	No
Does this patient have an autoimmune disorder?	Yes	No
Does this patient have autoimmune hepatitis?	Yes	No
Does this patient have decompensate cirrhosis?	Yes	No
Is this patient >60 years of age?	Yes	No

Most recent AST value (and range over the past 6 months) _____ (_____)
(submit copy of lab reports)

Has this patient had a liver biopsy? Yes No (If Yes – please submit a copy of biopsy report)

Most recent HCV RNA level _____ copies/ml
(submit copy of lab report)

HCV Genotype _____
(submit copy of lab report)

Other information regarding this referral request for GI consult related to Hepatitis C evaluation for therapy,

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THIS REQUEST CANNOT BE APPROVED WITHOUT ALL INFORMATION BEING PROVIDED